STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285189	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - St John's	3410 Central Avenue Kearney, NE 68847

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Licensure Reference Number NAC 175 12-006.09(H) Based on record reviews and interviews, the facility failed to follow physician orders, and ensure follow up assessments were completed for 1 (Resident 4) of 3 sampled residents. The facility identified a census of 51. Findings are: Record review of the facility policy titled, Change in Condition Evaluation last reviewed 04/06/2025 revealed the following: Purpose -To improve communication between nurses and a provider when nursing is monitoring a change of condition -To enhance the nursing evaluation of and documentation of a resident who has a change in condition To provide a standard format to collect pertinent clinical data prior to contacting the provider when there is a change in condition To standardize shift to shift communication about a resident change in condition Procedure Nursing judgment should be used when determining the urgency of contacting the provider. In the event the situation requires calling 911, the Change of Condition Evaluation (CICE) would not be used. Before completing CICE: -Review the resident's medical record including diagnosis, medications, recent progress notes from a medical doctor/nurse/practitioner/physician's assistant and consultants, as well as the most recent interdisciplinary notes. -Check with other staff members who have regular contact with the resident to obtain an accurate picture of the change of condition. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of progress notes and assessments in Resident 4's Medical Records revealed no CICE completed. A record review of an Order Summary Report dated as of 06/01/2025 revealed the following orders: -Ipratropium-Albuterol Inhalation Solution .5-2.5 (3) milligram(MG)/3milliliter(ML), 3 milliliter inhale orally every 4 hours as needed for wheezing. Order date: 05/16/2025 -Ipratropium-Albuterol Inhalation Solution .5-2.5 (3) milligram(MG)/3milliliter(ML), 3 milliliter inhale orally two times a day for wheezing. Order date: 06/16/2025-06/30/2025 A record review of Progress Notes and Medication Administration Record for June 2025 revealed Resident 4 received medication Ipratropium-Albuterol Inhalation Solution for each as needed (PRN): June 2nd at 4:21 PM for wheezing, results: Effective with decrease congestion by Registered Nurse (RN)-B June 3rd at 8:36 PM for wheezing, results: Effective by Medication Aide (MA)-C June 8th at 7:07 AM and 3:46 PM for wheezing, results for both: Effective no audible wheezing noted documented by RN-B June 14th at 2:37 PM for wheezing, results: Effective by RN-D June 15th at 7:04 AM for cough, results: Effective by RN-D June 23rd at 2:24 PM for wheezing, results: Unknown by MA-E June 24th at 3:06 PM for wheezing, results: Ineffective by MA-F A record review of Resident 4's Progress Notes on a communication to the Physician, 6/25/2025 at 3:55 PM revealed: cough worse this am, has nebulizer twice a day (bid) and every four hours (q4h) as needed (PRN), notified physician cough still and worse, they said to increase the prn treatments to see if helps and if not to get (gender) in for appointment to check aspiration possibly, also will try leave head of bed elevated at night. June 27th at 1:24 PM for wheezing, results: Effective by MA-E June 28th at 10:52 AM for wheezing and coughing, results: Effective by Licensed Practical Nurse (LPN)-A June 28th at 2:41 PM for wheezing, results: Effective by MA-F June 29th at 3:00 AM for wheezing, results: Effective by LPN-G A record review of Resident 4's Progress Notes on administration for medication revealed: Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML 3 milliliter inhale orally two times a day for wheezing PRN was given right before 6 AM dosage so did not do scheduled dosage at this time (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	June 29th at 6:28 AM for wheezing, results: Ineffective still wheezing by LPN-A at 8:12 AM June 29th at 11:07 AM for wheezing, results: Effective by MA-F A record review of Resident 4's Progress Notes on a communication to the Physician, 6/29/2025 at 3:13 PM revealed: Resident noted to have increased weakness. VS stable. resident continues to have wheezing with a non-productive cough. Nebulizer treatment given every 4 hours while awake this weekend. Skin dry. Appetite poor all weekend. (Spouse-gender) understanding of resident decline and aware of (gender) wheezing could be caused from (gender) Hiatal hernia. Family Member 1 would like resident seen in clinic tomorrow just to be evaluated. June 29th at 3:41 PM for wheezing, results: Effective by MA-F A record review of Resident 4's Progress Notes on a communication between the family and the facility on 6/29/2025 at 7:32 PM revealed: Resident Family Member 2 at facility concerned about change in condition of resident, gender asked for me (nurse) to check temperature, O2 sat, and listen to lungs. Resident was 78% on room air, was placed on oxygen via nasal cannula at 3 liters rose to 83%. Resident audibly wheezing, using accessory muscles for breathing, cannot talk, has temperature of 100.1 degrees Fahrenheit. Resident Family Member 2 called Family Member 1 who decided on sending gender to hospital for evaluation. An interview on 07/02/2025 at 9:25 AM, LPN-A revealed a new order for Ipratropium-Albuterol Inhalation Solution on 06/16/2025 for scheduled administration twice a day due to increased wheezing. Then described RN-B called the clinic on 06/23/2025 about continued wheezing, then RN-D called on 06/25/2025 due to worsening cough and to increase the Ipratropium-Albuterol Inhalation Solution PRN dosage, and to get the Resident in the clinic if no improvement or if the facility felt aspiration was a possibility, but no new orders were given. During an interview on 07/02/2025 at 9:30 AM, the LPN-A stated they did not feel like Resident 4 was in respiratory distress at the time, and do not recall whether or not they assessed Resident 4's lungs. An interview on 07/02/2025 at 10:05 AM with MA-F revealed they monitor efficacy of treatment. An interview on 07/02/2025 at 10:15 AM, the Director of Nursing Services (DNS) revealed the facility did not complete an assessment of treatment for Resident 4. In addition, the DNS further revealed that MA's should not be monitoring whether or not the medication is effective when it comes to the use of medication Ipratropium-Albuterol Inhalation Solution, a licensed nurse should monitor this. When asked about the communication to the physician on 6/25/2025 at 3:55 PM, which revealed: cough worse this am, has nebulizer bid and q4h as needed (PRN), notified physician cough still and worse, they said to increase the PRN treatments to see if helps, why treatments were not increased or change of condition was not appropriate. The DNS reports, they (nurses) could have done more.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(I) Based on record reviews and interviews, the facility failed to implement a plan of care to prevent potential injuries for 1 (Resident 9) of 3 sampled residents. The facility identified a census of 51. Findings are: Record review of the facility policy titled, Fall Prevention and Management last reviewed 04/08/2025 revealed the following: Purpose -To promote resident well-being by developing and implementing a fall prevention and management program. -To identify risk factors and implement intervention before a fall occurs Proactive approach before a fall occurs (e.g., New Admit) Procedure -On admission or readmission, review the applicable documents (i.e., discharge summary from transferring agency, transfer record, history and physical, lab values, nursing admit/readmit data collection) and any additional admit information documentation for fall risk factors. -Complete the Falls Tool UDA (User Defined Assessment) for fall screening and identifying fall risk factors. -Care Plan the appropriate interventions, including personalizing all areas. -Communicate fall risks and intervention to prevent a fall before it occurs per the 24-hour report, care plan and Kardex (a documentation system used by nurses to organize and quickly reference key patient information). -Communicate any identified environmental changes or needs (e.g., dietary, therapy). Record review of Resident 9's admission Record revealed the resident was admitted to the facility on [DATE] with the following diagnosis: -Stable burst fracture of unspecified lumbar vertebra, subsequent encounter for fracture with routine healing (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Unspecified dementia (loss of memory, language, problem-solving and other thinking abilities) without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety -Unspecified fracture of fourth lumbar vertebra, subsequent encounter for fracture with routine healing -Generalized anxiety disorder (an abnormal and overwhelming sense of apprehension and fear) -Depression (a mental health condition characterized by persistent sadness, loss of interest in activities, and changes in mood, behavior, and physical well-being) A record review of Resident 9's Falls Tool UDA in assessments on 07/02/2025 revealed none were completed. Record review of Resident 9's Progress Notes dated 06/27/2025 through 07/02/2025 revealed on 06/27/2025 at 3:06 PM Resident 9 admitted to facility. Alert to self only. Advanced dementia. Mumbles to self. Unable to answer questions. gender is present at bedside to answer questions. Put alarms on per gender request due to multiple falls in the last 2 weeks. Record review of Resident 9's Progress Notes dated 06/27/2025 at 3:54 PM revealed for Resident 9 safety facility asked gender to move resident closer to Nurses station, gender verbally agreed. Record review of Resident 9's Progress Notes dated 06/28/2025 at 12:00 PM revealed: What is being monitored daily: -Nursing to monitor vital signs, pain, surgical site to mid-lumbar, mood and behavior, ADL and transfer needs, lung sounds, participation in skilled therapies and any other abnormalities noted. Nursing interventions provided/required by nursing to address the resident's medical condition: -Resident with dementia and does not verbalize with staff. Resident with minimal eye contact. Resident requires 1 assist to dress. Resident bears weight but does not pick up feet or follow directions to pivot to toilet. Resident restless and tries to get up in which staff toilet resident and does void. How effective are the interventions/what progress is the resident making: -Resident remains on room air. No shortness of breath noted. Lungs clear. Will monitor for abnormalities. Resident with order for skilled therapies due to recent fall with lumbar fracture and surgical repair. Resident also has a left rib fracture. Record review of Resident 9's Progress Notes dated 07/01/2025 at 07:40 PM revealed: -Resident's alarm sounding. Resident found on the floor beside gender wheelchair. Lying face down. Unwitnessed. Resident unable to explain what happened due to cognitive deficits. Abrasion to right eyebrow. Physician, family and Director of Nursing Services (DNS) notified. Vitals and Neurological checks started per policy. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Licensed Practical Nurse-A (LPN-A) on 07/02/2025 at 09:15 AM revealed Resident 9 was sitting in the wheelchair in the living area alone when the resident fell. LPN-A was asked where the Baseline Care Plans (BCP, a plan of care for the resident that includes the minimum information needed to provide effective, person-centered care immediately upon admission) were located to view the interventions to prevent accidents. LPN-A handed this surveyor a binder labeled Care Plans. Record review of Resident BCP for Resident 9 revealed no BCP in the binder. During an interview on 07/02/2025 at 9:30 AM with the Health Information Manager (HIM) reported they were not certain why the BCP was not completed at the time of admission, pulled a blank form from the binder and stated they will look for it. On 07/02/2025 at 10:05 AM HIM revealed the BCP was found in their office, the BCP was dated 06/30/2025 which revealed: -The resident is provided therapy services for all disciplines. The BCP reveals Resident 9 is confused, forgetful, non-verbal and uses an alarm. Additional information reveals Resident 9 is high risk for falls demonstrated by confusion. During an interview on 07/02/2025 at 11:05 AM the DNS revealed that it is their expectation that staff complete the BCP within 12-24 hours of admission. The DNS further agreed that BCP interventions were not implemented timely to prevent accidents for Resident 9.